DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G057	A. BUILDING _____ B. WING _____	03/22/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	426 "Q" STREET, NW WASHINGTON, DC 20001

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W 000	INITIAL COMMENTS A recertifiction survey and death investigation (Client #5) was conducted from March 20, 2007 through March 22, 2007. A random sample of four clients was selected from a client population of eight clients with varying degrees of disabilities. This deceased client was the designated as the focus client in this survey. This survey was initiated using the fundamental survey; however, due to concerns in the area of health and safety, the survey was extended to examine the Condition of Participation in Active Treatment, Client Protection and Health Care Services. The finding of this survey were based on observations at the group home and three day program, interview with direct care staff and management, and a review of the habilitation and administrative records to include the unusual incident reports on file. Note: On March 12, 2006, the Department of Health was notified via facsimile of the death of Client #5 that occurred on March 12, 2007. The results of the investigation were based on interviews with the Qualified Mental Retardation Professional (QMRP), the home manager, two direct care support associates, nursing staff (1 LPN and the Director of Nursing (DON). In addition, review of medical and habilitation records were completed.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Gyoney Stephen | President | 4/30/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Governing Body failed to provide general operating direction over outside services: The findings include: 1. The Governing Body failed to ensure that agency personnel had been trained on the implementation Medical Emergency Policy and Procedures. [See W122, W149, W318, W322 and W331] 2. The Governing Body failed to have an effective system to ensure that Client #5 personal property was inventoried as outlined in the agency's Death Policy and Procedures. [See W137] 3. The governing Body failed to ensure that contract pest control services were effective and assisted in providings a sanitary environment. [See W454]	W 104	Please see answer to W122, W149, W318, W322 and W 331. An inventory was conducted on 03/23/07 and all the items were secured safely. Please see answer to W 454	3-23-07
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observations, interviews, and record reviews, it was demonstrated that the failed to document having informed each client, or surrogate healthcare decision-maker as appropriate, the risks associated with taking controlled medications and the right to refuse treatment [W124]; failed to ensure personal	W 122		

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W 122	Continued From page 2 property was secured after the death one of the clients residing in the facility as described in the agency's policy and procedures [See W137]; failed to implement establish written policy to clearly address incident management, injuries of known and unknown and ;facility failed to document prompt notification of parents or guardians of significant incidents or change in health status [See W148]; failed to ensure that medical personnel were notified for each clients' health and safety [See W149]; facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator[See W153]; failed to ensure that all injuries of unknown origin were thoroughly investigated [See W154]; facility Qualified Mental Retardation Professional (QMRP), failed to adequately monitor, integrate and coordinate each client's health and safety [See W159]; failed to ensure that each employee had been provided with adequate training that enables the employees to perform his or her duties [See W189]. The findings of these systemic practices results in the facility's failure to adequately govern the facility in a manner that would ensure that its clients' rights to be protected from potentially harmful.	W 122	Please see answer to W124, W137, W148, W149, W 153, W154, W 159 and W189.	
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	W 124		

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W 124	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to document having informed each client, or surrogate healthcare decision-maker as appropriate, the risks associated with taking controlled medications and the right to refuse treatment, for two of the four clients in the sample. (Clients #2 and #4) The finding includes: 1. Review of Client #2's medical record on June 2, 2006 at approximately 2:30 PM revealed that the client was given Ativan 3 mg as a sedation for an audiological examination. There was no evidence that written informed consent was obtained for the use of sedation. 2. The evening medication pass was observed on March 20, 2007 at 5:15 PM, Client #4 received Zyprexa 2.5 mg. The nurse indicated that the client receives this medication for his maladaptive behaviors to include aggression. During the record verification process, it was confirmed by on the client's physician order dated March 2007, that the client received Zyprexa 2.5 mg twice a day for his maladaptive behaviors. On March 21, 2007, further review of Client #4's record failed to show evidence that written informed consent had been obtained for the use of the medication. There was no evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to the client. The client's Psychological Assessment, dated November 18,	W 124	1. Client # 2's written consent was obtained prior to audiological examination [Please see enclosed consent form.] Attachment "A" 2. Client receives the said medication for his maladaptive behaviors including aggression. Which is an established maintenance doze for client # 4. A consent for psychotropic medication administration was obtained for client # 4 by [redacted] which already explains the risks and benefits of treatment. (Please see attachment) "B"	6/2/06 2/22/07

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W 124	Continued From page 4 2006, indicated the client's cognitive abilities tested in the severe range of retardation and he lacked the capacity to process information effectively to make sound decisions. The psychologist had assessed the client as not being capable of making informed decisions, the facility failed to document attempts to secure an appropriate surrogate decision-maker. [See W263]	W 124	Client # 4's sister Mr. [redacted], the legal guardian and surrogate decision maker appointed by the court. (See court report) C1 to C5	
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure personal property was secured after the death one of the eight clients residing in the facility as described in the agency's policy and procedures. (Client #5) The finding includes: Interview with the Director and the Quality Assurance Coordinator on March 22, 2007 at 11:00 PM, did not revealed that the agency prepared a personal property inventory after Client #5's death. Review of the records did not evidence that any of these conversations had been documented to include the disposition of the client personal property and funds.	W 137	DCHC had a detailed meeting with Client # 5's sister on 03/12/07 at 2:00PM. At that time. The topic of discussion was funeral arrangements, Personal property, personal finances of # 5. At the request of the family- we have to defer the discussion About his personal property for another day of their choosing. The sister was called for a meeting on 04/18/07. She verbally told us to donate all his property to DC 5. She and her family was very happy with the funeral arrangements.	

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W 137	Continued From page 5 Review of the agency's "Death of a Resident Policy" in the "Disposition of Property" section included the following: " An inventory of funds and property will be taken by the residential program five (5) working days of being notified of the death. This information will be accessible to the family, guardians, and Case manager. Every one jointly determine the final disposition of the property such as clothing, television, furniture, etc. Balance of finances will be forwarded to the District of Columbia Government through the Case Manager."	W 137	DCHC has amended our policy to accommodate personal space following such bereavement which now reflects 30 days instead of 5. (Please see attachment) "D"	4-1-07
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to document prompt notification of parents or guardians of significant incidents or change in health status, for one of the four clients in the sample. (Client #4) The finding includes: Interview with the QMRP and Review of Client #4's medical record revealed a physician's progress note dated March 2, 2007. The note described Client #4 with two abrasions on his upper lip. Treatment and follow-up care were not provided until March 5, 2007. On March 20, 2007 at approximately 9:00 AM, during the entrance	W 148	QMRP was in-serviced on reporting all unusual incidents based on the latest DDS's office of investigation and compliance unit policy on 04-03-07 by DCHC Incident Management Investigator. (See the attached sign in sheet & policy). Q — Q15	

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W 148	Continued From page 6 conference, the Qualified Mental Retardation Professional (QMRP) indicated the client had a legal guardian and who was very involved in his habilitation and care. Review of the incident report revealed that the guardian/family members were not notified of this injury. The QMRP further indicated that notification of guardians/family members are document on incident reports.	W 148		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that direct care staff implemented the agencies policy and procedure on reporting medical situations to medical personnel on of the client who resided in the facility to ensure prevention and safety. The finding includes: Interviews with the House Manager (HM), the direct care staff, medication nurse and the Director of Nursing (DON) and review of client #5's medical records and the facility's direct care staff communication log on March 20 and 21, 2007 provided evidence that the facility's direct care staff failed to follow their policy of reporting health changes to the appropriate medical personnel as evidenced by the following: a) Interview with the House Manager (HM) on March 20, 2007 at 12:15 PM revealed that on March 11, 2007 between 7 PM and 8 PM Client	W 149		

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W 149	Continued From page 7 #5's health status changed. He had an episode of vomiting and diarrhea and according to the HM, the client who usually requires minimal assistance with dressing, had to be assisted with his evening personal care (taking a bath and putting on his pajamas) and had to be assisted to bed. Although the HM documented in the facility's communication log during that evening that the client had vomited and encouraged the direct care staff that he should be watched, there was no documentation from the overnight shift of any concerns. Also there was no documentation that the medical/nursing staff was informed of the client's change in health status (vomiting, diarrhea and apparent weakness) as required by the facility's non emergency policy. According to the policy, medical personnel, [DON and primary care physician] must be called for various conditions to include diarrhea, vomiting, sudden decrease in activity. The HM confirmed that the facility's policy was not followed on the evening of March 11, 2007 as the appropriate medical personnel was not notified of the Client's change in health status. b) On March 20, 2007 two direct care staff were interviewed and reported that on the morning of March 12, 2007 the client was slow getting out of bed and appeared very weak as he needed assistance during his personal hygiene care. The direct care staff further stated that the client had to be assisted to the living room where he sat in his recliner chair. He did not get out of the chair to eat breakfast with his peers. The client, who was reported to need minimal assistance with feeding himself, had to be fed his breakfast in his recliner by the HM. There was no documentation	W 149	An in-service training was done on 04/13/07 for all the staff in the facility in emergency and Non-emergency medical problems & treatment, How to document non-emergency medical issues shift by shift. It is mandatory for all staff to follow this procedure effective 04-23-07. (See attachment format for daily log & training sheet). E1, E2.	04-13-07 04-23-07
			An in-service training was done on 04/13/07 for all the direct care staff on emergency and non-emergency policy, daily communication log and ~~a~~ new tool is developed for the entire shift to be used to avoid any communication loss. All staffs are required to fill a log sheet after each shift. All the logs will be available for nursing and medical personnel for review. [See tool and training]. E1 & E2	04/13/07

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W 149	Continued From page 8 in the facility's communication log or the client's medical record of the client's continuing decrease in activity. There was also no evidence that the decrease in activity was reported to the facility's medical personnel as required by the policy. c) Interview with the facility's medication nurse (LPN) on March 22, 2007 at approximately 4:00 PM and review of the nursing progress notes and physician's notes reported that the direct care staff informed the nurse on March 12, 2007 at 6:45 AM that the client was weak and had an upset stomach that morning. According to the nurse and the nursing notes the direct care staff did not inform the nurse of the client's had diarrhea and vomiting the previous evening (March 11, 2007). Although the nurse checked the client's vital signs and his abdomen and administered Pink Bismuth 30cc, there was no evidenced that the nurse contacted the appropriate medical personnel (DON or the Primary Care Physician) concerning the changes observed in the health of the client as required by policy.	W 149	An in-service training was done with nurse on 04/03/07. All pertinent medical concerns to be shared with DON & PMD. [See attachment.] F	04/03/07
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview, review of unusual incidents, and review of medical records, the facility failed to ensure that all unusual incidents including injuries	W 153		

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W 153	Continued From page 9 of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10) for one of the four clients in the sample. (Client #4) The finding includes: Review of Client #4's medical record revealed a physician's progress note dated March 2, 2007. The note described Client #4 with two abrasions on his upper lip. Treatment and follow-up care was not provided until March 5, 2007. This injury of unknown origin was not reported to the administrator or to the State Agency as required.	W 153	See answer to W148	
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all injuries of unknown origin were thoroughly investigated for one of the four clients in the sample. (Client #4) The finding includes: Review of Client #4's medical record revealed a physician's progress note dated March 2, 2007. The note described Client #4 with two abrasions on his upper lip. Treatment and follow-up care was provided until March 5, 2007. At the time of survey, there was no documented evidence that his family was in communication with the facility about this injury.	W 154	See answer to W148 See answer to W148 See answer to W148	

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W 154	Continued From page 10 The facility failed to provide evidence that the above incident was investigated to determine the origin of the injury.	W 154		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility Qualified Mental Retardation Professional (QMRP), failed to adequately monitor, integrate and coordinate each client's health and safety. The findings include: 1. The QMRP failed to ensure that Client #5 property inventory was completed as required by the agency's policy and procedures. [See W137] 2. The QMRP failed to ensure that direct care staff implemented the agency's medical protocol of notifying medical personnel in changes in each client's health status. [See W189] 3. The QMRP failed to ensure that the facility's staff implemented the agencies policy and procedure on reporting non emergency medical situations. [See W149] 4. The QMRP failed to ensure that clients received a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training. [See W197]	W 159	Client # 5's property inventory was done on 03/23/07. [See enclosed copy] 3/23/07 Please See W 137 - " G " See answer to W189. See answer to W149. See answer to W197.	

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W 159	Continued From page 11 5. The QMRP failed to ensure that an individual program plan (IPP) objective was developed to address a needs identified by the interdisciplinary team (IDT). [See W227] 6. The QMRP failed to ensure that clients were provided with opportunities for choice and self-management. [See W247] 7. The QMRP failed to ensure that each client received continuous active treatment including needed interventions. [See W249] 8. The QMRP failed to ensure that each client's Individual Program Plan (IPP) objectives were incorporated in their individual activity schedules. [See W250]	W 159	All the IPP programs were checked and any discrepancies in any of the program was revised as of 03/31/07. Please see answer to W247. Please see answer to W249. Please see answer to W250.	3-31-07
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employees to perform his or her duties effectively, efficiently and competently. The findings include: The facility failed to ensure that direct care staff were trained on the facility non-emergency medical policy and protocol of notification of medical personnel. [See W149]	W 189	Please see answer to W149.	

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W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observations, interviews, and record reviews, failed to ensure clients residing in the facility are provided services/care for e clients who has demonstrated generally independent and is able to function with minimal/little supervision [W197]; failed to ensure that an individual program plan (IPP) objectives were developed to address identified needs by the interdisciplinary team (IDT) [W227]; failed to ensure clients were provided with opportunities for choice and self-management [W247]failed to ensure that each client received continuous active treatment including needed interventions[W249]; failed to ensure that each client's Individual Program Plan (IPP) objectives were incorporated in their individual activity schedules [W250]; failed to revise program objectives once the client successfully completed [W255]; failed to review and revise the Individual Program Plan (IPP) once the client is being considered for training towards a new objective[W258]; ; failed to ensure that restrictive programs were approved by the facility's HRC [W262] ; and failed to ensure that each client's behavior intervention program, including the use of behavior modification drugs, was conducted only with the written informed consent [W263]. The effects of these systemic practices resulted in the facility's failure to adequately govern the facility in a manner that would ensure its clients' continuos active treatment and habilitation needs.	W 195	Please see answer to W 149. An in-service training was held on 04/13/07 for all direct care staff on IPP goals, BSP, Data Collection, Active treatment, Activity schedule, choices and self management. All the IPP program were rechecked and placed in the book as of 03-31-07. 4-13-07 An in-service training was also done for direct care staff on 04/12/07 on modified program of the identified individuals. 4-12-07 [Please see attached in-service sheet.] Attachment G1, G2 + H1, H2.	

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W 197	483.440(a)(2) ACTIVE TREATMENT Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program. This STANDARD is not met as evidenced by: Based on observation, interview, and the review of records, the facility provides services/care for one client (Client #1) who has demonstrated generally independent and is able to function with minimal/little supervision in the absence of a continuous active treatment programs. The findings include: A. Client #1 ' s program and activities failed to show that the need for continuos activity treatment and the need for basic activity of daily living programs as evidenced below: Interview with Client #1 and record verification on March 20, 2007 at 5:05 PM revealed that he is competitively employed at a local grocery store. He works 40 hours a week and earned a check biweekly. The Client informed the surveyor that he enjoys his job and described his responsibilities/duties to included janitorial task and stocking of shelves. According to the direct care staff and the habilitation/vocational records, the client performs these duties without a job coach and minimal supervision. Interview with the HM and direct care staff revealed that the client independently performed chores at his residence that include taking out the trash, cleaning the kitchen and bathrooms and assist with planning meals and grocery shopping. Observation on March 20 and March 21,	W 197 A	Client # 1 is one of the identified individual who will be moving to CRF upon approval received from DDS. Client #1 is employed at a grocery store and works 32 hours a week and earns check biweekly. Client # 1 is not competent enough to make a decision according to finance matter and also requires assistance in grooming and hygiene skills. Client # 1 has a program in cognitive domain to count ten $ 1 bills independently which is not achieved. Also as cited client # 1 is not very social on various occasions. Client # 1 did not like to socialize with Any one at the Chateau Night Club. Client # 1 has a program to increase his human sexuality skills and ask a lady to dance while at Chateau. The program is not completed because of client# 1's constant refusal. Staff was in-serviced IPP documentation and data collection. Client # 1 does not have adequate judging skills or ability to make decision that are in his best interest. Many socializing opportunities have been consistently being offered to client#1. He has so far not responded in a way that shows interest or desire to pursue it. DCHC will continue to work with client # 1, So that skills can be taught for him to move into a less restrictive setting program will be reviewed in the upcoming ISP on 5-14-07	5-14-07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 197	Continued From page 14 2007 and Interview with HM and direct care staff on March 22, 2007 revealed that the client was very social and did not display any maladaptive behaviors. According to interview with the client, he enjoyed going out to night clubs and other social/leisure recreation events. Interview with the Client and with the direct care staff on March 20, 2007 revealed that the client has the skills to make his needs and wants known and to make appropriate choices. For example, the client informed the surveyor that he had a desire to handle his own banking. He received a payroll check bi-weekly and would like an opportunity to deposit the check in the bank instead of giving it to the QMRP for deposit in the local banking institution. He also informed the surveyor and staff that he wanted to terminate his day program, which he was scheduled to attend once a week . Interview with Day Program Coordinator On March 20, 2007 at approximately 11:30 Am and review of the client day program IPP revealed that the client has a travel training program that was to be implemented at the client ' s day program. According to the DPC, the client did not want to attend the day program which was scheduled once a week. The DPC contacted the QMRP to inform him that the day program would be willing to follow through with this program but reportedly the QMRP informed the day program that since he did not want to attend the day program, the home would implement the travel training program. Review of the program records did not evidence that the IDT had reconvene to amend this program in order for implemented during the residential programming. Additionally, there was no documented evidence that the IDT addressed Client #1 decision to remain at home and develop	W 197	Client # 1 has a money management program to count ten $1 bills and there is no subsequent progress in that program. During a concern meeting held at the house on 01/26/07 the IDT team had decided to continue with the current money management program and start a banking program during the forth coming ISP with a travel training program and a travel training and banking program is started as of 04/12/07.	4-12-07

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W 197	Continued From page 15 an alternative program structure to meet his needs. On March 21, 2007 review of the client's Individual Program Plan (IPP) dated January 2, 2007 revealed objectives that the client has accomplished and program domain that there was little need for training. a) The client had a self medication training program that required the client to after set by.the medication nurse was to participate in the administration of his Am medication regimen. Review of the data collection sheet indicated that the client performed these tasks independently. b) The client had a money management program to count and make small purchases. According to the data and staff, the client was able to complete this program with minimal supervision and independence. The client requested that he be trained in how to go to the bank and deposit his payroll check. c) The client had a Speech and Language program to write his name and telephone number by a model. The client refused to participate in this program; therefore, the IDT revised the program on July 10, 2006 to include the use of a computer. There was no evidence that the revised program had been implemented, excepted on one occasion. Observation of the facility and interview with stat ff rev revealed that the client did not have a computer available for the resident in the group home to implement this program. d) The client had an objective to increase human sexuality skills by asking a lady to dance with him. The client attended a night club twice a month staff indicated that his social behaviors were appropriate. e) The client was determined to independence in personal hygiene ' s, with the exception of wiping	W 197	a. Client #1's medication assessment tool is modified to 100% independence. Client #1 will follow a 10 steps medication administration with 100% independence for 3 consecutive months. Nurse in-charge will continue to monitor. (See attached tool) attachment I b. A banking program is developed and implemented as of 04/12/07 for client #1 in conjunction with his existing money management program. attachment 'J' c. Client # 1 received a computer as of 04/06/07 and revised program was implemented as 04/10/07. An in-service training for staff was also done to make sure that program is implemented properly. attachment 'K' d. Client #1's human sexuality objective is not achieved. Client #1 refuses to participate in the program, program will be modified during his upcoming ISP and pre ISP meeting is on 05/14/07 to meet his need.	5-1-07 4-23-07 4-10-07 5-14-07

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W 197	Continued From page 16 thoroughly following bowel elimination. According to the staff he is being verbally reminded before toileting. Review of the data did indicated that he needed minimal assistance in this task. f) The client had no training need in fine and gross motor. g) The client had no training need in behavior management. h) The client had a training objective to be travel trained and reportedly the group home accepted responsibility for its implementation and failed to present it at the an IDT to establish criteria for the objective. Is should be further noted that the client is not attending a weekly staff meeting required for hi job placement. According to the day program personnel Client #1 could travel independently to his job site. This would elevate the group home responsibility for transporting him and allow for his independence. According to the HM the facility transport him to and picks him up from his job. Additionally, he does not like being picked up late from work. The facility failed to identify, provide and/or reinforce the client ' s training needed to prepare the client for transition to a least restrictive residential placement.	W 197 e, f ,g h	be No concern to addressed. Client #1 has a travel training program effective 04/06/07. Client #1 is getting training to use bus from house to Whole Foods and will be picked up by the house staff from work. During the upcoming ISP meeting on the basis of progress program will be modified to better meet his needs if needed. (See attached format of program) 1+2+4	04-06-07
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that an individual program plan (IPP) objectives were	W 227	In addition client # 1 is waiting to be transferred to a CRF based on DDS approval.	

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W 227	Continued From page 17 developed to address identified needs by the interdisciplinary team (IDT) in the comprehensive assessment for two of the four clients in the sample. (Clients #1 and #3) The findings includes: 1. Interview with the Qualified Mental Retardation Professional (QMRP) and review of habilitation record revealed a Speech Language assessment dated June 29, 2006 in which the IDT team agreed for this therapist to implement a program goal for Client #1 to "Use a computer to type his address and telephone number with independence for 3 consecutive months by June 2007". Further interview with the QMRP revealed that the client has been to the main office to use the administration computer once. Further review of the assessment revealed that the rational for implementation of the client use of a computer to indicated the following: "[The Client] has not been successful using paper and pen. Changing the media used will hopefully enhance the acquisition of this skill as well as teach him some computer skills" At the time of the survey, the QMRP reported that computer needed for this client to participate in this training objective had not been purchased for Client #1's use. 2. Interview with the QMRP and review of records for Client #1 revealed that he was required to participate in a self-medication program to accomplish the following task: a. Pick up the package of medicine	W 227	1. Client #1 received a computer as of 04/06/07. A program session of training was done by the speech pathologist. Client #1 will receive staff assistance to complete the task. An in-service training for staff was also done on the same day to ensure proper implementation of the IPP objective. Please see attachment K	4-6-07

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W 227	Continued From page 18 b. Pop pills from the package into the medicine cup c. Pour water into cup d. Take medicine e. Drink water f. Put cup in trash Review of the program data sheet failed to define the objective criteria, to determine level of Client #1's participation and time period of implementation of this objective. 3. The facility failed to develop Client #3's meal preparation and putting the dinnerware away after being washed as indicated in the comprehensive functional assessment. a. Interview with the direct care staff and the certified food handler's personnel on March 21, 2007 at approximately 4:00 PM revealed that Client #3 does not participate in any meal preparation. Review of Client #3's Occupational Therapist Assessment dated January 22, 2007 revealed a program objective that stated, "[the client] should assist in meal preparation twice weekly with verbal cues on 95% of the trials record per month for three consecutive months". However, there was no evidence that this program objective was implemented at the time of the survey.	W 227	2. Client #1's medication assessment tool is modified to 100% independence. Client #1 will follow a 10 steps medication administration with 100% independence for 3 consecutive months. Nurse in-charge will continue to monitor. (See attached tool) T 3. An in-service training was done by [redacted] on 04/06/07 for all direct care staff to ensure that all the programs are followed throughly. All program objectives were checked and all the skills documentation was checked to ensure that all the programs are running without any complications.	5/1/07 4/6/07
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, interview, and record	W 247		

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W 247	Continued From page 19 review, the facility failed to ensure clients were provided with opportunities for choice and self-management for one of the four clients in the sample. (Client #1) The finding includes: The facility failed to ensure clients were given the opportunity to make choices in developing additional skill for money management . Interview with Client #1 on March 20, 2007, who indicated that he has a job at Whole Foods grocery store and that he enjoys his work. He was also able to describe his task and duties. He further indicated that his pay days were opposite the direct care staff pay day. He stated, "I don't know where my check goes?" The client explained that he would like to participate in the deposit of his payroll check, but he brought his checks homes and the checks were given to the QMRP. He did not participate in any banking transaction. Review of the habilitation and financial records on March 22, 2007 at approximately 10:30 AM, failed to provide information as to the client's participation and skills in banking transactions.	W 247	Client #1 is currently on a program to count ten (10) $ 1.00 bills. He does not program independently. To allow him more towards independence and control of his own finances, Client #1 will be provided supports to execute steps of making a bank deposit.	4/12/07
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

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W 249	Continued From page 20 This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that each client received continuous active treatment including needed interventions, for three of the four clients in the sample. (Clients #1, #2, #3) The finding includes: 1. [Cross reference W197] According to QMRP, the House Manager and the Day Program Coordinator, Client #1's Individual Program Plan (IPP) was not being implemented that included the following program objectives a. The client will be provided with job coaching and follow up services. b. The client will participate in community-based activities. c. The client will participate in supervised travel-training. 2. The facility failed to allow Client #2 to participate in his independent living skills program objectives. a. During medication observation on March 20, 2007 at 5:42 PM, the medication nurse was observed to wipe Client #2's hands with a sanitizing wipe. The nurse was further observe preparing the medication, pouring the clients water and handed the client the cup of medication and water and he complied with the nurse's instruction to take his medication. Interview with	W 249	1- a, b, c Please see answers to W 197	

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W 249	Continued From page 21 the medication nurse revealed that Client #2 has a self medication program. Review of the IPP dated January 20, 2007 revealed a program objective which stated, "[the client] will complete the steps of the administration of self medication". The steps for the client to completed were administered by the medication nurse. b. On March 20, 2007 at 5:00 PM, Client #2 was observed finishing his afternoon snack of cookies. The client was getting up from the dining room table with cookie crumbs around his mouth. The direct care staff was observed wiping the cookie crumbs from Client #2 mouth. Review of IPP dated January 20, 2007 revealed a program objective which stated, "[the client] will utilize napkin to wipe his mouth with verbal prompting on 80% of the trials recorded per month for three consecutive months. 3. The facility failed to utilize Client #2's adaptive communication device as recommended by the Interdisciplinary Team (IDT). a. On March 20, 2007 at 8:15 AM, Client #2 was observed pointing to the bathroom door. The direct care staff replied, "Do you have to go the the bathroom." b. On March 20, 2007 at approximately 4:35 PM, Client #2 was observed being offered an afternoon snack. The direct care staff stated to the client, "say thank you." According to the client IPP dated January 20, 2007, the client had a program objective which stated, "[the client] will use an AAC device to express a message (I'm going to the bathroom, thank you for the snack, and will you dance with me please) on three of the four training sessions for three consecutive	W 249 2- a. 2. b. 3- a&b.	An in-service training was done for the nurse on duty on 04/07, to ensure proper medication administration and also to make sure that clients do learn to be more independent. "Attachment F" An in-service training was done on 04/13/07 to retain staff in IPP objective and implementation of each individual program. An in-service training was done on 04/13/07. Client #2's adaptive communication device will be kept in the activity area and QMRP will ensure that staff are retrained to ensure proper implementation.	4/3/07 4/13/07 4/13/07

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W 249	Continued From page 22 months. Interview with the QMRP revealed that the adaptive device was kept in the client bedroom not in the program area for the client's use. It should be noted that during the entire survey, the client was not observed using the adaptive communication device. 4. The facility failed to allow Client #3 to participate in activities of daily living skills. On March 20, 2007 prior to snack and dinner meal, Client #3 was observed setting the dining room table for both snack and the dinner meal. Interview with the direct care staff indicated that the client did not help or participate in meal preparation. The client was observed taking his dinner plate to the kitchen sink after all meals. Review of IPP dated January 20, 2007 revealed a program objective which stated, "[the client] will set the table with verbal cues prior to meal time on 95% of the trials recorded per month for three consecutive months. 5. The facility failed to develop and implement Client #3's meal preparation and putting the dinnerware away after being washed as indicated in the comprehensive functional assessment. a. Interview with the direct care staff and the certified food handler's personnel on March 21, 2007 at approximately 4:00 PM revealed that Client #3 does not participate in any meal preparation. Review of Client #3's Occupational Therapist Assessment dated January 22, 2007 revealed program objective that stated, "[the client] should assist in meal preparation twice weekly with verbal cues on 95% of the trials	W 249 4. 5. a.	An in-service training was done on 04/05/07 for all direct care staff to ensure proper implementation of all the programs. All IPP objective were reviewed and put in place as of 04/01/07. Client #3 does not have a program to cook meal but Client #3 does help in kitchen twice a week. Staffs were in-serviced for proper implementation.	4/5/07 4/1/07

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W 249	Continued From page 23 record per month for three consecutive months". At no time during the survey was this objective observed being implemented. b. Observations on March 20, 2007 after breakfast and dinner meal and afternoon snacks revealed other clients and staff putting dishes and silverware in the cabinets after being washed. Review of Client #3's Occupational Therapist Assessment dated January 22, 2007 revealed a program objective which stated, [the client] will place all dinnerware/silverware into appropriate storage place following washing on 95% of the trials record per month for three consecutive months". At no time during the survey was this objective observed being implemented.	W 249 b.	All IPP objectives were reviewed and implemented as of 04/01/07. A in-service training was also held for all direct care staff to ensure effective implementation of the programs.	4/1/07
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client's Individual Program Plan (IPP) objectives were incorporated in their individual activity schedules for one of the four clients in the sample. (Client #1) The finding includes: 1. On March 20 - 22, 2007, Client #1 was observed participating in a variety of activities during the AM and PM hours. Interview with Client #1 revealed that he was employed with	W 250		

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W 250	Continued From page 24 Whole Foods Grocery. Further interview with Client #1 revealed that he was at the group home on his days off Tuesday and Thursday. Additionally, the client also revealed that he attends a day program one day a week. Interview with the Qualified Mental Retardation Professional (QMRP) confirmed that Client #1 was competitively employed at Whole Foods and works 40 hours over a four day period (Friday, Saturday, Sunday and Monday). Reportedly the clients work schedule was12:00 PM to 8:00 PM. Further interview with the QMRP revealed that Client #5 is off from work on Tuesday and Thursdays. According to the QMRP, on those days the client was involved in cleaning assignment at the group home, in food shopping for the home and recreation/leisure activity of his choice. Additionally, the QMRP reported that Client #1 attends his supported employment day treatment program on Wednesdays. Interview with Client #1's supported employment Day Program Coordinator on March 21, 2007 at approximately 11:15 AM Client #1 revealed that the Client has not been attending the program. According to the Coordinator, Client #1, the "Client has a job and did not want to attend this one day a week program". Further interview with the QMRP later the same day, revealed that Client #1 has a current activity schedules that included his current IPP goals and objectives as recommended by the interdisciplinary team. There was no activity schedule that reflected the Client's current activities and training programs.	W 250	1. Client #1's activity schedule was reviewed and replaced with the most current IPP objectives. Client #1 attends his day program once a week and never showed any interest or concern that he don't want to go to school. Client #1 was not feeling well for couple of days which lead him to be absent from the day program. Also client # 1 has an activity schedule for the days he stays home. Please see attachment. P.I.P 4 All the activity schedules are reviewed and revised on 04/01/07.	4-1-07
W 255	483.440(f)(1)(i) PROGRAM MONITORING &	W 255		

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W 255	Continued From page 25 CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to revise program objectives once the client successfully completed an objective for two of the four clients in the sample (Clients #3 and #4) The findings include: 1. The QMRP failed to revise Client #4's Behavior Support Plan (BSP) objectives once he meet the established criteria. a. Observation of the medication pass on March 20, 2007 at 5:25 PM, Client #4 was observed being administered Zyprexa 2.5 mg. Interview with the medication nurse revealed that the medication was used for his maladaptive behaviors. Review of the client's BSP dated February 22, 2007 revealed that psychotropic medications are used in the BSP to address his maladaptive behavior of aggression. Further review of the Individual Program Plan (IPP) dated December 12, 2007 revealed IPP objectives which stated, "[the client] will maintain zero incidents of aggression for 12 consecutive months". Review of the psychologist quarterly reviews and behavior data sheets from January	W 255 1. a.	Client #4's BSP objective has been revised as of 05/01/07. The BSP objective and data collection methodology has been changed as of 05/01/07. Currently he is on a minimal effective doze for optimum functioning.	5-1-07 5-1-07

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W 255	Continued From page 26 2006 through February 2007 revealed zero incidents. Additional Interview with the QMRP indicated that the client is on a maintenance dosage of psychotropic medication, therefore requiring a BSP. b. Review of Client #4's IPP dated December 12, 2007 revealed an objective which stated, "[the client] will identify ten pictures by naming and pointing with 50% independence for three consecutive months by December 2007". Review of the Speech Pathologist quarterly reviews from April 2006 through October 2006 indicated that the client achieved the program objective, however continue for stabilization. 2. The QMRP failed to revise Client #3's therapeutic recreation objective once he meet the established criteria. Observations on March 20, 2007 at approximately 7:00 PM, Client #3 was observed going on a community outing with his housemates. Interview with the direct care staff on March 21, 2007 at approximately 6:00 PM, revealed that the client participates in many house and community outings. Review of the IPP dated December 12, 2006 revealed that the client had an objective which stated, "[the client] will be provided opportunities to participate in three to five activities per week at a rate of 75% accuracy". Review of the Recreation Quarterly dated January 2007 and interview with the QMRP confirmed that the client participates in many community outings as well as home activities.	W 255	b. Even though Client #4 accomplished the established criteria, based on his retaining ability and level of retardation, he needs consistent trainings thereby speech therapist requested for stabilization. However during the June 2007 IPP meeting the program will be revised. 2. Client #3 does participate in various activities as stated in recreation objectives with staff assistance and supervision. However the staff were documenting the data wrongly therefore an in-service training was done by recreational therapist on 04/13/07. QMRP & HM will make sure on weekly basis to check the proper documentation. (Please see the attachment) ~ M /	6-11-07 4-13-07 5-1-07
W 258	483.440(f)(1)(iv) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at	W 258		

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W 258	Continued From page 27 least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is being considered for training towards new objectives. This STANDARD is not met as evidenced by: Based on observations, staff interviews and record review, the Qualified Mental Retardation Professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the client is being considered for training towards a new objective in the IPP for one of the four clients in the sample. (Clients #1) The findings include: The facility's QMRP failed to revise Client #1's Speech and Language program objectives. Interview with the QMRP and review of habilitation record revealed a Speech Language assessment dated June 29, 2006 a program goal for Client #1 to "Use a computer to type his address and telephone number with independence for 3 consecutive months by June 2007". Further review of the assessment revealed that the rational for recommending that the client's use was because: "[The Client] has not been successful using paper and pen. Changing the media used will hopefully enhance the acquisition of this skill as well as teach him some computer skills". Review of Client #1's program data sheets and	W 258	Client #1's computer was purchased by program implementation as of 04/10/07. Orientation was given by speech pathologist on 04/16/07. The old program has been discontinued.	4-10-07 4-10-07 & 4-16-07 4-16-07

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W 258	Continued From page 28 the Speech Language consultant monthly notes indicated that Client #1 continued to use paper and pen to write his address and phone number from a model. There was no evidence that this program had been discontinued so that the new program could be initiated.	W 258		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Human Rights Committee (HRC) failed to review and approve the use of restrictive measures, for one of the four clients in the sample. (Client #2) The finding includes: On March 21, 2007, review of the HRC minutes and interviews with the Qualified Mental Retardation Professional (QMRP) revealed the there was no evidence that the HRC had approved the use of Client #2's Ativan for an audiological medical consult. [See W124]	W 262	Please see answers to W 124 (Page 4)	
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.	W 263		

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W 263	Continued From page 29 This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure program which incorporate restrictive techniques and use of behavior modification were conducted only with written informed consent of the client, or legal guardian for one of the four clients in the the sample. (Client #4) The finding includes: There was no evidence of written informed consent for the use of Client #4's restrictive measures that was included in the Client's behavior support plan. [See W124]	W 263	Please see the answer to W 124	
W 316	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually. This STANDARD is not met as evidenced by: Based on observation, client and staff interview and record review, the facility failed to ensure that medications used for control of inappropriate behavior had been gradually withdrawn at least annually for one of the four clients in the sample. (Client #4) The finding includes: On March 20, 2007 at 5:25 PM, Client #4 was observed being administered Zyprexa 2.5 mg. Interview with the medication nurse and the Qualified Mental Retardation (QMRP) indicated that the medications were used for his maladaptive behaviors. Further interview with the QMRP and review of the Behavior Support Plan	W 316		

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W 316	Continued From page 30 (BSP) on March 21, 2006 indicated that Client #4's BSP addressed aggression. Record verification of the BSP dated February 22, 2007 indicated that the following maladaptive behavior was included in the BSP: aggression (property destruction) picking up objects that cause harm. The objectives for the aforementioned behavior stated, "[the client] will maintain zero incidents of aggression for 12 consecutive months. According to the data sheets and the Psychologist quarterly reviews from January 2006 through February 2007 revealed that the client had not displayed the targeted maladaptive behaviors. There was no evidence that the client's IDT had addressed a reduction in psychotropic medications as the client achieve the behavior management criteria.	W 316	Even though Client #4 accomplished the established criteria, based on his retaining ability and level of retardation, he needs consistent trainings thereby speech therapist requested for stabilization. However during the June 2007 IPP meeting the program will be revised. Client #3 does participate in various activities as stated in recreation objectives with staff assistance and supervision. However the staff were documenting the data wrongly therefore an in-service training was done by recreational therapist on 04/13/07. QMRP & HM will make sure on weekly basis to check the proper documentation. (Please see the attachment). M	6-11-07 4-13-07
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interviews, and record reviewed, failed to ensure that direct care staff implemented the agencies policy and procedure on reporting medical situations to medical personnel [See W149]; the facility failed to establish systems to provide health care monitoring and identify services that would ensure nursing services were provided in accordance with clients needs [Refer to W331]; failed to ensure health services were provided to meet the needs of the clients [W322]; failed to	W 318	Please see the answer to W 149, W 331, W 322, W 356 & W 393	

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W 318	Continued From page 31 provide each client with nursing services in accordance with their needs [W331]; failed to schedule timely dental appointments [W356]; and failed to ensure it met the requirements for performing glucose monitoring testing [W393]. The results of these systemic practices results in the demonstrated failure of the facility to provide health care services.	W 318		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure general and preventive care for one eight clients residing in the facility. (Client #5) The finding includes: Interviews with the House Manager (HM), the direct care staff, medication nurse and the Director of Nursing (DON) and review of client #5's medical records and the facility's direct care staff communication log on March 20 and 21, 2007 provided evidence that the facility's direct care staff failed to follow their policy of reporting health changes to the appropriate medical personnel as evidenced by the following: a) Interview with the House Manager (HM) on March 20, 2007 at 12:15 PM revealed that on March 11, 2007 between 7 PM and 8 PM Client #5's health status changed. He had an episode of vomiting and diarrhea and according to the HM, the client who usually requires minimal	W 322	An in-service training was done on 04/13/07 for all direct care staff in emergency and non-emergency medical policy of DC Health Care.	4-13-07

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W 322	Continued From page 32 assistance with dressing, had to be assisted with his evening personal care (taking a bath and putting on his pajamas) and had to be assisted to bed. Although the HM documented in the facility's communication log during that evening that the client had vomited and encouraged the direct care staff that he should be watched, there was no documentation from the overnight shift of any concerns. Also there was no documentation that the medical/nursing staff was informed of the client's change in health status (vomiting, diarrhea and apparent weakness) as required by the facility's non emergency policy. According to the policy, medical personnel, [DON and primary care physician] must be called for various conditions to include diarrhea, vomiting, sudden decrease in activity. The HM confirmed that the facility's policy was not followed on the evening of March 11, 2007 as the appropriate medical personnel was not notified of the Client's change in health status. b) On March 20, 2007 two direct care staff were interviewed and reported that on the morning of March 12, 2007 the client was slow getting out of bed and appeared very weak as he needed assistance during his personal hygiene care. The direct care staff further stated that the client had to be assisted to the living room where he sat in his recliner chair. He did not get out of the chair to eat breakfast with his peers. The client, who was reported to need minimal assistance with feeding himself, had to be fed his breakfast in his recliner by the HM. There was no documentation in the facility's communication log or the client's medical record of the client's continuing decrease in activity. There was also no evidence that the	W 322	Please see answers on page 32 for W 322	

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W 322	Continued From page 33 decrease in activity was reported to the facility's medical personnel as required by the policy. c) Interview with the facility's medication nurse (LPN) on March 22, 2007 at approximately 4:00 PM and review of the nursing progress notes and physician's notes reported that the direct care staff informed the nurse on March 12, 2007 at 6:45 AM that the client was weak and had an upset stomach that morning. According to the nurse and the nursing notes the direct care staff did not inform the nurse of the client's had diarrhea and vomiting the previous evening (March 11, 2007). Although the nurse checked the client's vital signs and his abdomen and administered Pink Bismuth 30cc, there was no evidenced that the nurse contacted the appropriate medical personnel (DON or the Primary Care Physician) concerning the changes observed in the health of the client as required by policy. According to interview with the staff, LPN, the QMRP and review of his medical records the limited functioning ability exhibited by Client #5's and the decrease in his health status on both March 11 and March 12, 2007 was unusual. Reportedly he was very talkative and usually made unfounded verbally threats and would apologize to seek attention especially from the staff. There was no evidence prior to 3/11/07 that the client had been ill or experienced vomiting episodes or had periods of weakness.	W 322	An in-service training was held with all direct care staff in reporting unusual changes and sudden decrease in client's health status (See attachment) E1	4-13-07
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.	W 331		

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W 331	Continued From page 34 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide each client with nursing services in accordance with their needs for two of the eight clients residing in the facility. (Clients #3 and #5) The finding includes: 1. The facility's medication nurse failed to ask staff pertinent questions to ascertain the client's full health status to complete a thorough assessment.[See W322] 2. The facility's nurse failed to scheduled an endocrinology/diabetic appointment for Client #3. Review of Client #3's medical record revealed a diagnosis of diabetes. Further review of the client's annual physical recommended that a endocrinology appointment be scheduled as soon as possible (ASAP). Additional review of a physician order dated November 28, 2006 revealed an order to schedule and endocrinology/diabetic clinic ASAP. At the time of the survey there was no evidence that the endocrinology consult had been scheduled.	W 331	Please see answers to W 322 It is very hard to get an endocrinology appt. After various unsuccessful attempt client # 3 has a endocrinology appt. on 06/15/07 @ 9.15 AM at WHC. Nursing team of DCHC make sure that f/u are done in proper time.	6-15-07
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by:	W 356		

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W 356	Continued From page 35 Based on observation, staff interview, and record review, the facility failed to schedule timely dental appointments for two of the four clients in the sample. (Clients #3 and #4). The findings include: 1. On March 20, 2007, Client #3 was observed with brown stains on his teeth. Record review of the dental consultation dated December 6, 2005 revealed that the client had "heavy calculus deposits, and an X Ray was taken." The dentist recommended that the client needed scaling and that they dental office would submit for authorization. There was no evidence that the recommended dental services had been performed in the a year and approximately three months. 2. On March 20, 2007, Client #4 was observed with stains on his teeth. Review of the clients medical record revealed a dental consultation dated July 24, 2006 and was recommended that the client needs scaling ASAP. Interview with the House Manager revealed that the client receives dental services under the "Medicaid Waiver" program. The dentist stated, "major problem with reimbursement. Until this dental office rectifies the situation, we will no longer see "Medicaid Waiver" patients. Call back in September 2007. " There was no evidence that the recommended dental services had been performed.	W 356	Client # 3 was seen by the dentist on 06/02/06 for scaling. Due to systemic problem with DDS & MAA, the dentist was not able to get a medical authorization program., thus resulting in receiving no services. Follow up was done on 11/22/06, where generalized scaling was done with recommendation return in six months. A follow up appointment was obtained for 05/07/07. See attachment N:1 + N 2 Client # 4 lives in an ICF/ MR he is not on a medicaid waiver program - checking with the dentist it was understood that DDS dentist might have reported wrongly , classifying him in medicaid waiver. He also have a dental appointment for 05/07/07.	5-7-07 5-7-07
W 393	483.460(n)(1) LABORATORY SERVICES If a facility chooses to provide laboratory services, the laboratory must meet the requirements	W 393		

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W 393	Continued From page 36 specified in part 493 of this chapter. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure it met the requirements for performing glucose monitoring testing for one of four clients in the sample. (Client #3) The finding includes: Interview with the medication nurse on March 20, 2007 at approximately 5:45 PM, revealed that Client #3 has a diagnosis of diabetes. The medication nurse further revealed that the client provides a urine sample each morning to test his glucose level. Additionally, the medication nurse informed the surveyor that the client's urine is tested for ketones and the test strips are used for this process. The test strips are dipped in the client's urine and are compared with a color chart on the test bottle for comparative reading. The medication nurse records the glucose level on the medication administration record, daily. Interview with the Qualified Mental Retardation Professional and and the Director March 22, 2007 at approximately 12:30 p.m. revealed that the provider did not have a certificate of waiver as required by part 493 of the Clinical Laboratory Improvement Act (CLIA).	W 393	DCHC is in process to get a certificate of waver under CLIA. A fax was already send to CLIA office for requesting some information about certificate. (Please see enclosed) We will secure CLIA by 05/31/07	Ongoing
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the	W 436		

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W 436	Continued From page 37 interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to effectively teach the client to maintain them for one of the four clients in the sample. (Client #2) The finding includes: On March 20, 2007 at 8:15 AM, Client #2 was observed pointing to the bathroom door. The direct care staff replied, "Do you have to go the the bathroom," and the client entered the bathroom. At approximately 4:35 PM, Client #2 was observed being offered an afternoon snack. The direct care staff stated to the client, "say thank you." According to the client IPP dated January 20, 2007, revealed a program objective which stated, "[the client] will use an AAC device to express a message (I'm going to the bathroom, thank you for the snack, and will you dance with me please) on three of the four training sessions for three consecutive months. It should be noted that during the entire survey, the client was never observed using the adaptive communication device.	W 436	An in-service training was done on 04/06/07 for all direct care staff to ensure proper implementation of IPP objective for Client #2.	4-6-07
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on review of fire drill records, the facility failed to hold evacuation drills at least quarterly for each shift of personnel.	W 440		

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W 440	Continued From page 38 The finding includes: Interview with the Qualified Mental Retardation Professional on March 20, 2007, 2006 revealed that the staff shifts are as follows: 6:30 AM -10:30 AM; 2:30 PM - 10:30 PM; 10:30 PM - 6:30 AM Monday through Friday and 6:30 AM -2:30 AM; 2:30 PM - 10:30 PM; 10:30 PM - 6:30 AM Saturday and Sunday Review of the fire drill log revealed that the facility failed to hold fire evacuation drills for all shifts at least quarterly. There were five fire drills conducted on the 2:30 PM -10:30 PM shift for Saturday or Sunday. The drills were conducted on 1/5/06, 3/25/06, 12/4/06, 2/4/07, and 3/2/07. These above findings were referred to the Office of the Fire Marshall.	W 440	All the direct care staff were in-serviced on 04/05/07 to ensure that fire drills are held once a month in each shift. QMRP will ensure that all the drills are conducted and filed in the book as per the regulations.	4-5-07
W 454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a sanitary environment to avoid sources and transmission of infection. The finding includes: On March 21, 2007 at approximately 11:20 AM, a mouse was observed to run from the kitchen into the living room underneath a couch. The mouse was further observed to stand on his hind legs while under the couch and then proceeded to run	W 454	DC Health Care has a pest control management contract with Am-Pest Control In. The company provides a monthly and on call visits.	

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W 454	Continued From page 39 from underneath that couch to the opposite side of the living room under the another couch. Interview with the facility's Qualified Mental Retardation Professional (QMRP), Quality Assurance (QA) Coordinator and the Director indicated that the pest control company had a standing monthly visit to this group home for treatment of pest. There was no evidence that the pest control company's treatment was effective in eliminating pest in order to provide a continuos sanitary environment.	W 454	DCHC has contract with American Pest Control Inc. who service the facilities on routine basis. DC is infested with rodent problem which is an ongoing issue. However APC company was called and facility was serviced again on 05/01/07. DCHC will continue to service it's facility on routine basis and as needed.	5-1-07

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I 000	INITIAL COMMENTS A licensure survey and death investigation (Client #5) was conducted from March 20, 2007 through March 22, 2007. A random sample of three clients was selected from a client population of six clients with varying degrees of disabilities. The deceased client was the designated as the focus client in this survey. This survey was initiated using the fundamental survey, however, due to concerns in the area of incident management the survey was extended to examine the Condition of Participation in Active Treatment, Health Care Service and Client Protections. The finding of this survey were based on observations at the group home and three day program, interview with direct care staff and management, and a review of the habilitation and administrative records to include the unusual incident reports on file. Note: On March 12, 2006, the Department of Health office was notified via facsimile of the death of Client #5 that occurred on March 12, 2007. The results of the investigation were based on interviews with the Qualified Mental Retardation Professional (QMRP), the home manager, two direct care support associates, nursing staff (1 LPN and the Director of Nursing (DON). In addition, review of medical and habilitation records were completed.	I 000		
I 092	3504.3 HOUSEKEEPING Each GHMRP shall be free of insects, rodents and vermin.	I 092		

Gomey Stephen — TITLE President — (X6) DATE 4/30/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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I 092	Continued From page 1 This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure it was maintained free from rodent and vermin. The findings include: See Federal Deficiency Report Citation W454	I 092	Please see answer to W 454	
I 108	3504.15 HOUSEKEEPING Each GHMRP shall assure that each resident has at least seven (7) changes of clothing appropriate to his or her daily activities. This Statute is not met as evidenced by: Based on observation and staff interview, the GHMRP failed to provide an adequate amount of undergarments for one of the three residents in the sample. (Resident #1) The finding includes: During the environmental inspection on March 21, 2007 at 3:40 PM, Resident #1 had two pair of undergarments in his dresser drawer. At the completion of the licensure survey, the facility failed to provide additional undergarments for Resident #1 use.	I 108	Client # 1 has many pairs of undergarments. Client # 1 sometimes hides stuff from his dresser under bed or behind the dresser as reported by the staff. QMRP will ensure that all clients have atleast 7 pairs of clothing in the dresser at all the time.	ongoing
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by:	I 135		

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I 135	Continued From page 2 Based on interview and record review, the GHMRP failed to ensure that each shift conducted a fire drill four times a year. The finding includes: See Federal Deficiency Citation W440	I 135	Please see answer to W 440.	
I 187	3508.5(d) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (d) The lines of authority. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the accurate delineation of authority with regards to programmatic and environmental responsibilities. The finding includes: During interview with the facility's QMRP on 3/21/2007 at 12 PM, revealed no clear line of authority and the changes communicated in the organizational structure in the regards to ensuring the proper assessment of the resident ' s care, programmatic needs, and ensuring the maintenance/upkeep of the physical environment of the home. Record review revealed the existing organizational chart failed to include position changes, names and roles establish lines of authority.	I 187	Organizational chart was reviewed and corrected as of 04/01/07 to include position changes. Names and roles. [Please see enclosed].	04-01-07
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and	I 206		

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I 206	Continued From page 3 annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current health certificates for all employees annually. The finding includes: Review of the personnel files on March 20, 2007, the GHMRP failed to provide current health certification for one direct care staff (TW), the Nutritionist.	I 206	Please see the attached Health Certificate - attachment "E"	
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for all personnel. The finding includes: See Federal Deficiency Report Citation W189	I 222	Please see answer to W189.	
I 374	3519.5 EMERGENCIES After medical services have been secured, each	I 374		

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I 374	Continued From page 4 GHMRP shall promptly notify the resident ' s guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident ' s status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure notification of the occurrence of incidents The findings include: See Federal Deficiency Report - Citation W148, W153 and W154	I 374	Please see answer to W148, W153, and W154.	
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to provided ongoing diagnostic and evaluation for services for three of three resident's in the sample. (Resident #3 and #5) The findings include: See Federal Deficiency Report Citation W331, W322	I 401	Please see answer to W331 and W322.	

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I 421	Continued From page 5	I 421		
I 421	3521.2 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to residents in the most normalizing environment and the least restrictive circumstances. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure habilitation and training for one of the four residents included in the sample. (Resident #1) The finding includes: See Federal Deficiency Report - Citations W197	I 421	Please see answer to W197	
I 423	3521.4 HABILITATION AND TRAINING Each GHMRP shall monitor and review each resident ' s Individual Habilitation Plan on an ongoing basis to ensure participation of the resident and appropriate GHMRP staff in revision of such Plans whenever necessary. The schedule for the reviews shall be documented within each IHP. This Statute is not met as evidenced by: Based on observation, staff interview and record review the Group Home for Mentally Retarded Person (GHMRP) failed to ensure the habilitation and skill building of residents as required by this section. [Residents #2, #3] The findings include: See Federal Deficiency Report citations W255 and W263	I 423	Please see answer to W255 and W263.	

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I 424	Continued From page 6	I 424		
I 424	3521.5(a) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure program revisions were made at least every six months or when a resident successfully completed the objective. The finding includes: (See Federal Deficiency Report-Citation W255)	I 424	Please see answer to W 255.	
I 427	3521.5(d) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (d) Is being considered for training toward a new objective or objectives; or... This Statute is not met as evidenced by; Based on interview and record review, the GHMRP failed to ensure modifications were made to the residents individual program plan in conjunction with the Individual Support Plan meeting. The findings include: See Federal Deficiency Report Citation W255	I 427	Please see answer to W 255.	

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I 437	3521.7(g) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (g) Communication (including language development and usage, signing, use of the telephone, letter writing, and availability and utilization of communications media, such as books, newspapers, magazines, radio, television, telephone, and such specialized equipment as may be required); This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to implement Speech and Language objective as outlined in the annual assessment for one of the four residents in the sample. (Resident #1 and #3) The finding includes: See Federal Deficiency Report - Citation W227	I 437	Please see answer to W 227.	
I 458	3521.11 HABILITATION AND TRAINING Each resident ' s activity schedule shall be available to direct care staff and be carried out daily. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure each resident's activity schedule was carried out daily The finding includes: (See Federal Deficiency Report - Citations W197 and W250)	I 458	Please see answer to W197. and W 250	